Bureau of Licensure and Certification

		(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NVN444AGC		NVN444AGC		B. WING		09/04/2008		
NAME OF PROVIDER OR SUPPLIER S WHISPERING HEIGHTS			2397 EMPII	STREET ADDRESS, CITY, STATE, ZIP CODE 2397 EMPIRE RANCH ROAD CARSON CITY, NV 89701				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
Y 000	Initial Comments			Y 000				
	a result of the annual conducted in your fact Licensure survey was of NRS 449.150, Pow The facility is license for Group beds for elected Category I residents. The survey was six. So reviewed and three elected in your factor of the survey was six.	mployee files were arge file was reviewed.	y ate nority ion. cility sons, e of					
Y 103 SS=E	449.200(1)(d) Personnel File - NAC 441A			Y 103				
	a separate personnel member of the staff of	se provided in subsection I file must be kept for each of a facility and must incompared pursuant of or the employee.	ach clude:					
	NAC 441A.375 Medic dependent and home care: Management of cases; surveillance a counseling and preve 1. A case having tube considered to have to facility or a facility for managed in accordant	ot met as evidenced by cal facilities, facilities for se for individual resident for cases and suspected and testing of employees entive treatment. Berculosis or suspected suberculosis in a medical the dependent must be called the guidelines control and Prevention	r the tial s; case I e of the					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

A. BUILDING

NVN444AGC 09/04/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING _

WHISPERING HEIGHTS			RE RANCH ROA SITY, NV 89701	AD.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI	1.1.2.17		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 1		Y 103		
	adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the depended a home for individual residential care shall maintain surveillance of employees of the factor home for tuberculosis and tuberculosis infection. The surveillance of employees must conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities proving the transmission of tuberculosis of the Centers for Disease Control and Prevention adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person emploin a medical facility for the depended a home for individual residential care shall have a subsection from licensed physician that the person is in a state good health, is free from active tuberculosis within the preceding 12 months, including persons with history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first of a 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must administered. A single annual tuberculosis screening test must administered thereaffunces the medical director of the facility or history of the facility of the designee or another l	cility st be e iding as oyed ent or ave n a ste of and gious n a step in the of the be ter, nis			

PRINTED: 09/30/2008 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN444AGC** 09/04/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2397 EMPIRE RANCH ROAD WHISPERING HEIGHTS **CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 103 Continued From page 2 Y 103 exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis.

Based on record review on 9/4/08, the facility did not ensure that 1 of 3 employees had the required tuberculosis (TB) documentation.

Employee #2: Date of hire 3/27/08. The

Findings include:

Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVN444AGC 09/04/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WHISPERING HEIGHTS		2397 EMPIRE RANCH ROAD CARSON CITY, NV 89701					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
Y 103	Continued From page 3 employee's file contained a negative chest x report dated 5/14/08. The file did not contain evidence in the form of a positive skin test or physician statement that the resident had texture positive for TB. The file did not contain the resident of a physical examination or a physician certification that the employee was in a state good health, was free from active TB and an communicable disease in a contagious stage. Severity: 2 Scope: 2	n r a sted esults e of					
Y 936 SS=D	NAC 449.2749 1. A separate file must be maintained for ear resident of a residential facility and retained least 5 years after he permanently leaves th facility. The file must be kept locked in a plat that is resistant to fire and is protected again unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related the resident, including without limitation: (e) Evidence of compliance with the provision chapter 441A of NRS and the regulations adopted pursuant thereto.	for at e ace ast d to					
lf deficiencies	This Regulation is not met as evidenced by NAC 441A.380 Admission of persons to cert medical facilities, facilities for the dependent homes for individual residential care: Testing respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120) 1. Except as otherwise provided in this section before admitting a person to a medical facilitie extended care, skilled nursing or intermediation, the staff of the facility shall ensure that	tain t or g; on, ty for ta					

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

(c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step

tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has

sooner.

Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	NVN444AGC	STREET ADD	RESS, CITY, STA	TE ZIP CODE		04/2006	
NAIVIE OF P	ROVIDER OR SUPPLIER			RE RANCH RO				
WHISPERING HEIGHTS				ITY, NV 8970				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	CTION SHOULD BE COMPLET THE APPROPRIATE DATE		
Y 936	Continued From page 5		Y 936					
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		and g the raph ot me east es a 3 ther other of the in old and graph not on, ealth es son off of on to on in					

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of the Centers for Disease Control and

(g) of subsection 1 of NAC 441A.200.

person 's medical record.

3-28-96; R084-06, 7-14-2006)

Prevention as adopted by reference in paragraph

7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive

tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the

(Added to NAC by Bd. of Health, eff. 1-24-92; A

Based on record review and interview on 9/4/08, the facility did not ensure that 1 of 6 residents had received the required tuberculosis (TB) skin

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FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN444AGC** 09/04/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2397 EMPIRE RANCH ROAD WHISPERING HEIGHTS **CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 936 Continued From page 7 Y 936 testing. Findings include: Resident #4: Date of admission 3/21/08. The file contained documentation the resident completed the required two-step TB skin testing on 7/7/07. The file did not contain proof the resident received an annual one-step TB skin test for July of 2008. To comply with NAC 441A, the resident needs to complete an additional two-step TB skin test. Severity: 2 Scope: 1